SOUTH PLAINFIELD HEALTH DEPARTMENT
2480 Plainfield Avenue, South Plainfield, NJ 07080

RETAIL FOOD ESTABLISHMENT APPLICATION

ESTABLISHMENT *INFORMATION:*

Name: _____ Phone #: _____

Address:: _____ Fax #: _____

OWNER *INFORMATION:*

Name: _____ Phone # _____

Address: _____

EMERGENCY CONTACT PERSON:

NAME: _____ TITLE: _____

EMERGENCY/AFTER HOURS PHONE NUMBER: _____

FEE SCHEDULE

ESTABLISHMENT SIZE/TYPE AND MISCELLANEOUS FEES		AMOUNT
1 - 1,000 SQ. FT.	*ONE HUNDRED TWENTY-FIVE DOLLARS ($125.00)*	_____
1,001 - 5,000 SQ. FT.	*TWO HUNDRED DOLLARS ($200.00)*	_____
5,001 - 10,000 SQ. FT.	*TWO HUNDRED FIFTY DOLLARS* ($250.00)	_____
OVER 10,000 SQ. FT.	*FIVE HUNDRED DOLLARS ($500.00)*	_____
MILK FEE	*TWENTY-FIVE DOLLARS* ($25.00)	_____
DRUG STORE	*SIXTY DOLLARS ($60.00)*	_____
ICE	T*WENTY-FIVE DOLLARS* ($25.00)	_____
LATE PENALTY	*FIFTY DOLLARS A MONTH ($50.00/MONTH)*	_____
NON-ATTENDANCE (OF FOOD COURSE)	*ONE HUNDRED FIFTY DOLLARS* ($150.00)	_____
	TOTAL AMOUNT:	_____

NOTE: APPLICATION IS TO BE COMPLETED AND RETURNED WITH A CHECK *PRIOR TO MARCH 31ST* OF THE YEAR IN WHICH THE LICENSE IS ISSUED.

FOR OFFICE USE ONLY.

LICENSE # _____ DATE ISSUED: _____

METHOD OF PAYMENT: CASH $_____ CHECK $_____ CHECK NUMBER _____